MO HealthNet Managed Care
Annual Quality Report for SFY 2010
Executive Summary

Introduction

MO HealthNet Managed Care serves participants in 54 counties of Missouri, which are divided into three regions: Eastern, Central, and Western. MO HealthNet Managed Care contracts are competitively bid and are currently awarded to six health plans. Three health plans operate in all three regions and three health plans operate in only one region resulting in a count of 12 health plans when doing regional comparisons. The MO HealthNet Division (MHD) is required to monitor MO HealthNet Managed Care health plans (MCHP) to ensure compliance with the MO HealthNet Managed Care contracts.

The MHD has conducted an evaluation of the MO HealthNet Managed Care Program for state fiscal year 2010 (SFY2010). Each MCHPs evaluation is divided into ten (10) sections: Development, Approval and Monitoring of the Quality Improvement (QI) Program, Population Characteristics, Quality Indicators, Accessibility of Services, Fraud and Abuse, Information Management, Quality Management, Rights and Responsibilities, Utilization Management and Performance Improvement Projects (PIPs). Each MCHP submitted an annual evaluation for SFY2010 as well as a work plan for SFY 2011.

Legislative Changes

As a result of passage of HB 11, 95th General Assembly, 2009 session, effective July 1, 2009, MO HealthNet Managed Care dental rates were increased. MO HealthNet Managed Care dental reimbursement rates will increase to 38.75% of the 50th percentile of usual and customary reimbursement.

Enrollment

Statewide enrollment in the MO HealthNet Managed Care program during SFY2010 increased to 421,756 from 401,314 in SFY2009 (based on June enrollment each year). Enrollment of CHIP members accounted for 11% (44,946) of the total.

Development, Approval and Monitoring of the QI Program

MCHPs reported on the development, approval and monitoring of their QI Program by providing reviews of their quality and compliance committees, the analysis of their quality improvement process, and the overall effectiveness of their quality improvement program.

MCHPs use the National Committee for Quality Assurance (NCQA) Healthcare Effectiveness Data and Information Sets (HEDIS) and the Consumer Assessment of Healthcare Providers and Systems (CAHPS) to uniformly measure progress in the quality of care offered to participants. By using HEDIS and CAHPS measures, the quality of care Managed Care members are receiving in Missouri can be compared to national rates.

The MHD analyzed thirty HEDIS measures submitted by the MCHPs. Analysis of the MCHPs 2011 HEDIS measures reflects improvement in rates in 81% of measures over 2010 HEDIS. Additionally, 39% of the measures rank higher than NCQA's national rate.

2011 HEDIS measures with statewide improvement over 2010 HEDIS:

- Adolescent Well-Care Visits
- Annual Dental Visits – (all age ranges, seven measures)
- Asthma (all age ranges, three measures)
- Cervical Cancer Screening
- Childhood Immunizations (Combo 3)
- Chlamydia Screening Combined Rate
- Well Child Visits First 15 Months of Life: 0 Visits and 6+ Visits (two measures)
- Well Child Visits in the Third through Sixth Year of Life
- Prenatal Care
- Post-Partum Care
- Follow-Up After Hospitalization for Mental Illness within 7 Days of Discharge
- Follow-Up After Hospitalization for Mental Illness within 30 Days of Discharge

2011 HEDIS measure with statewide rates above the NCQA national rates:

- Asthma Age 5 – 9
- Cervical Cancer Screening
- Chlamydia Screening (all age ranges, three measures)
- Well Child Visits in the First 15 Months of Life: 4 and 5 Visits (two measures)
- Prenatal Care
- Post-Partum Care
- Follow-Up After Hospitalization for Mental Illness within 7 Days of Discharge
- Follow-Up After Hospitalization for Mental Illness within 30 Days of Discharge

Analysis of the MCHPs 2011 CAHPS measures reflects an improvement in 62.5% of measures over 2010 CAHPS. Additionally, 50% of CAHPS measures rank higher than NCQA national rates.

2011 CAHPS results with statewide improvement over 2010 CAHPS:

- Getting Needed Care
- How Well Doctors Communicate
- Customer Service
- Rating of Specialist
- Rating of Health Care
- Rating of Plan

2011 CAHPS results with rates above the NCQA national results:

- Getting Needed Care
- Getting Care Quickly
- How Well Doctors Communicate
- Customer Service
- Rating of Doctor
- Rating of Specialist
- Rating of Health Care
- Rating of Plan

MCHPs HEDIS and CAHPS scores demonstrate continued efforts to provide quality health care to Managed Care members. Continued collaboration between quality units and health plan management will ensure interventions to improve service and clinical care.

Network Analysis

The Missouri Department of Insurance, Financial Institutions, and Professional Registration (DIFP) reviews the annual access plans submitted by the MCHPs to determine if Managed Care members have reasonable access to providers and specialists in their area. The DIFP calculates the enrollee access rate for each type of provider in each county the MCHPs serve with a statewide goal of 90%. The entire Managed Care population is used in the calculation for each MCHP.

- The 2010 network analysis completed by the DIFP determined that all MCHPs met and exceeded the 90% standard with the exception of one health plan. A plan of action was submitted by that health plan to address the issue. Five (5) MCHPs obtained an overall network score of 100% in their respective regions, Six (6) scored 99% in their respective regions and one (1) scored 97%.
- 10 of 12 MCHPs achieved 100% in the PCP distance standard per State regulation 20 CSR 400-7.095(3)(A)1.B. The remaining two (2) health plans achieved 99%.
- All MCHPs dentist/enrollee ratios were within the benchmark dentist/enrollee ratios.

Rights and Responsibilities

Rights and Responsibilities are measured by each MCHP reviewing its member grievance and appeals; provider complaint, grievance, and appeals; as well as member confidentiality practices.

The MHD reviews quarterly reports submitted by the MCHPs to monitor member grievances and appeals as well as provider complaints and appeals. Beginning January 1, 2006 all MCHPs began using a standardized database for reporting member grievances and appeals and provider complaints and appeals.

MCHPs reported a low incidence of member grievance and appeals. Annually, member grievances range from 0.46 (Missouri Care, Western region) to 8.69 (HCUSA, Eastern region) per 1,000 members with the most prevalent issues related to transportation. Member appeals range from 0.00 (Missouri Care, Western region) to 4.46 (Missouri Care, Central region) per 1,000 members with the most prevalent issue being service denials.

Fraud and Abuse

Fraud and Abuse is measured by each MCHP reviewing its prevention, detection, and investigation practices as well as training and education practices. Beginning in SFY 2006 the MCHPs started using a uniform reporting system for their quarterly reports to the MHD. When appropriate, the MCHPs report to and cooperate with the MHD Program Integrity Unit, Medicaid Fraud Control Unit (MFCU), the Attorney General's Office, and other agencies that conduct investigations for the purpose of exchanging information and strategies for addressing fraud and abuse, as well as allowing access to documents and other available information related to program violations.

Performance Improvement Projects (PIPs)

Performance Improvement Projects are measured by reviewing clinical and non-clinical PIPs, as well as on-going interventions and improvements.

The focus of the PIPs is to study the effectiveness of clinical or non-clinical interventions. These projects should improve processes associated with healthcare outcomes, and/or the healthcare outcomes themselves. They are to be carried out over multiple re-measurement periods to measure: 1) improvement; 2) the need for continued improvement; or 3) stability in improvement as a result of an intervention. The MCHPs are required by contract to have at least two active PIPs, one of which is clinical in nature and one non-clinical.

MCHPs have identified the following PIPs:

Molina HealthCare of Missouri

- Members at High Risk for Cesarean Section Wound Infections
- Adolescent Well Care

HealthCare USA

- Post Partum Depression
- Annual Dental Visit
- Beary Important Bundle (BIB) Peer-to-Peer Educational Baby Shower
- Readmissions
- Synagis
- Adolescent Well Care
- Decreasing Non-Emergent/Avoidable ED Utilization
- Mental Health Follow-up After Hospitalization: Improving Post-Discharge Management of Members Discharged from an Inpatient Setting for Mental Illness
- Obesity Reduction CODE BEAR
- Improving Coordination of Care for members diagnosed with ADHD and prescribed medications
- Attention Deficit Hyperactivity Disorder (ADHD) Behavioral Health Program

Missouri Care

- Increase Use of Controller Medication for Members with Asthma
- WIC Partnership to Increase Well Child Checkup Compliance
- Increase Compliance with Chlamydia Screening Recommendations (CHL)
- Adolescent Well Care
- Annual Dental Visits
- Increasing the Number of Lead Screening Tests for Children
- Follow-Up after Hospitalization for Mental Health (FUH, 7- and 30-day)

Children's Mercy Family Health Partners

- Cervical Cancer Screening
- Improving Comprehensive Diabetic Screening Rates

Blue Advantage Plus

- Ambulatory Follow-Up within 7 Days of Hospitalization
- Improving Oral Health

Harmony Health Plan

- Increasing Lead Screening in Children Ages 0 – 2 Years
- Increase Annual Dental Visits, Ages 2 to 20
- Weight and Nutrition Management for Children
- Increase Adolescent Well Care Visits

The Quality Assessment and Improvement (QA&I) Advisory Group decided in January 2010 to replace the Adolescent Well Care (AWC) state-wide PIP with an oral health state-wide PIP. (Ongoing monitoring of the effectiveness of the AWC initiatives by the State and MCOs will continue, however, and the HEDIS AWC measure will be used as a component of the auto assignment performance score for each MCO during the life of the current contract.) There was an increase in the AWC statewide average for HEDIS 2010 and 2011, but it remains 7.95% below the national NCQA average.

Behavioral Health Reviews

The MHD contracted with Mercer Government Human Services Consulting (Mercer), of Mercer Health & Benefits LLC, to conduct a clinical performance review of the Behavioral Health Organizations for four (4) of the MCHPs in 2008. Staff from MHD and the Department of Mental Health (DMH) conducted a clinical performance review of the behavioral health in-house operations for the two (2) remaining MCHPs in 2009, and for all MCHPs in 2010. The focus of the behavioral health reviews was to explore variances in behavioral health utilization and to identify any patterns of under or over-utilization that would suggest issues with access to or quality of care for Managed Care members. The reviews addressed the following areas with respect to utilization:

- Adequacy of quality monitoring systems including oversight of staff performance; caseloads; network access; provider practice patterns; utilization; denial and complaint trends and other quality data.
- Involvement of the Medical Director in utilization and quality management.
- Effectiveness of executive management, MCHP oversight, and reporting.
- Performance on a number of key metrics including telephone response, staff turnover, network access, and utilization and complaint rates.

Case Management Records lacked evidence of sufficient documentation across all MCHPs in the following:

- Participant case management,
- Care coordination with community resources,
- Assisting participants with accessing providers,
- Comprehensive outreach strategies to assist participants prior to the occurrence of an emergency, and
- Behavioral/medical health integration.

Required areas of improvement for all MCHPs include:

- Improve customer service workflow and outreach,
- Improve consistency of application of Level of Care Utilization (LOCUS) and the Child and Adolescent Level of Care Utilization System CAL/LOCUS,
- Expand access to inpatient diversion services (alternative services to inpatient care),
- Identify and implement best practices in service delivery for the Medicaid population,
- Assure discharge planning begins at admission; and
- Assure Behavioral Health Medical Director has direct line authority over and meaningful involvement in clinical operations, including accountability for monitoring over and under utilization.

As a result of the Behavioral Health reviews, each MCHP was required to submit a Corrective Action Plan addressing the findings and recommendations in the review report.

The Behavioral Health measures are reported to the QA&I Advisory Group, no less than annually, and are revised as necessary. The QA&I Advisory Group continues to address problems identified during the Behavioral Health Reviews.

External Quality Review

The United States Department of Health and Human Services (DHHS), Centers for Medicare and Medicaid Services (CMS) requires an annual, independent external evaluation of State Medicaid Managed Care programs by an External Quality Review Organization (EQRO). External Quality Review (EQR) is the analysis and evaluation by an approved EQRO of aggregate information on quality, timeliness, and access to health care services furnished by MCHPs and their contractors to Managed Care members.

The EQR technical report analyzes and aggregates data from three mandatory EQR activities and one optional activity as described below:

Validating Performance Improvement Projects

Each MCHP conducted performance improvement projects (PIPs) during the 12 months preceding the audit; six of these PIPs were validated through a combination of self-selection and EQRO review. The final selection of PIPs to be audited was determined by the State Medicaid Agency (SMA; Missouri Department of Social Services, MO HealthNet Division (MHD).

Validating Performance Measures

The three performance measures validated were HEDIS 2010 measures of Adolescent Well Care Visits (AWC), Follow-Up After Hospitalization for Mental Illness (FUH), and Annual Dental Visit (ADV).

MO HealthNet MCHP Compliance with Managed Care Regulations

The EQRO conducted all protocol activities, with the exception of the MCHP Compliance with Managed Care Regulations Protocol. The SMA conducted these activities and requested the EQRO to review them (Compliance Review Analysis).

Special Project – Case Management Record Review
The EQRO reviewed a random selection of Case Management files for each MCHP. These files were evaluated based on the requirements set forth in the MCHPs' contract with the SMA to deliver MO HealthNet Managed Care services.

The 2010 MO HealthNet Managed Care External Quality Review (EQR) Report of Findings can be found at http://dss.mo.gov/mhd/mc/pdf/eqro2010.pdf

Conclusion

The MO HealthNet Managed Care Annual Evaluations reveal a strong foundation for continued effort to provide quality health care to Managed Care members. Standardized reporting to MHD, as well as NCQA HEDIS/CAHPS measures, makes it possible to compare the MCHPs across the state and measure their progress in providing care to its members. MCHPs also recognize there are still areas for improvement.

The MHD is committed to working with the MCHPs and all stakeholders in building on the strengths shown in these annual evaluations.

Each MCHP provided detailed analysis in their SFY 2010 Annual Evaluations. The individual Executive Summaries from each of these reports follow.

MO HealthNet Managed Care Health Plan Annual Quality Evaluation
Executive Summaries
SFY2010 (July 2009 – June 2010)

Blue-Advantage Plus

Blue-Advantage Plus of Kansas City, Inc. (BA+) has provided outstanding service to members for over twelve years. BA+ continues to exceed the State's expectations of quality and performance and we are 100% compliant with the MO HealthNet's contract requirements.

Audit Results – During calendar year 2010, we had an EQRO audit. The audit was conducted by Behavioral Health Concepts, and the auditors had many compliments about our program. They were very enlightened with the interviews with the case managers and they were very impressed with our Performance Improvement Projects.

Quality Program –

- Blue Cross and Blue Shield of Kansas City (Blue KC) is accredited by the National Committee for Quality Assurance (NCQA) for certain of its health plans and programs. Blue KC has an accreditation status of ―Excellent, the highest level possible, for its commercial HMO product, Blue-Care, by the National Committee for Quality Assurance (NCQA). The company's Preferred-Care Blue PPO product has ―Full NCQA accreditation, the highest level awarded for PPO products by NCQA.
- Blue KC also holds over 95 percent of possible points, as well as distinction in NCQA's ―Quality Plus modules of ―Member Connections and ―Care Management and Health Improvement.
- Blue KC is also accredited by the Utilization Review Accreditation Committee (URAC) for several programs, including Health Provider Credentialing (including the BA+ network), and Health Utilization Management. Accreditation has been found to be associated with industry best practices.

Compliance – Remaining compliant and the ability to demonstrate compliance with all contractual requirements is important to Blue KC. Annually, a complete review of every contract requirement is completed in order to demonstrate compliance. Each requirement is measured and scored and documentation is maintained in compliance binders. The results of the compliance review are reported to the Quality Council. If there are situations where BA+ is out of compliance, these are reported to the Compliance Committee.

HEDIS® measures – Most of the measures maintained from the previous calendar year. BA+ experienced improvements in the following HEDIS® measures for CY2010.

- Cervical Cancer Screening
- Adolescent Well Care
- Chlamydia Screening for Women
- Follow-Up After Hospitalization for Mental Illness – 30 day
- Timeliness of Prenatal Care
- Postpartum Care
- Well Child Visits in the Third, Fourth, Fifth, And Sixth Year of Life

Oversight – BA+ continues to be overseen and monitored through Blue-Advantage Plus' Oversight Committee. This is a cross-functional Committee that ensures compliance with the contract and meeting quality standards.

BA+ looks forward to another great year of providing a quality program to our members.

OVERVIEW OF THE QUALITY IMPROVEMENT PROGRAM

The purpose of the Quality Improvement System is to provide the infrastructure for cross-departmental integration of quality improvement processes and outcomes into business activities in order to achieve the mission of Blue KC and the goals of BA+.

Blue KC will achieve this mission by providing to customers:

- Access to quality health providers;
- The knowledge necessary to make informed choices;
- Guidance through the health care system; and
- Superior service.

Blue KC has adopted an over-arching, company-wide quality program as a means to tie together and at least loosely integrate the many quality improvement activities, which occur within our company. To improve quality planning, a Quality Plan will be developed each year to complement Blue KC's Three-Year Business Plan, with the goal of improving the relevance of the quality improvement plan to the business plan. This important change sets the direction for the Quality Improvement System to be formally integrated with the business plan in the future, and allows thoughtful setting of corporate quality priorities consistent with the intent of "Building the Best with Blue".

The Blue KC mission statement is operationalized for BA+, as well as other Blue KC HMO, PPO, and Government Program products. This integration provides for rich resource availability to provide for the quality assessment and improvement program for BA+.

EVALUATION OF THE QUALITY IMPROVEMENT SYSTEM, RESOURCES, AND LEADERSHIP

Building the Best with Blue

At a local level, we again hosted the annual Blue KC ―Showcase of Quality for numerous business improvement project teams. In the spirit of continuous quality improvement, feedback for team participants and Blue KC leadership was used to redesign the award categories for broader cross-divisional representation, with new scoring guidelines to increase selectivity and objectivity in selecting award recipients.

Evaluation of Quality Improvement System

During 2008-2009, the strategic planning consultancy completed an in-depth review of Blue KC business systems and processes, resulting in recommendations to the Board of Directors in the fourth quarter 2008. Throughout 2009, Blue KC leadership continued to review strategic roadmaps, as well as structures for corporate work groups and accountability. Specific governance structures were set in place for each business division's strategic plan roadmaps(s).

Senior management leadership teams set priorities and policy, make decisions and review progress made toward completing the strategic roadmaps.

During 2010, we anticipated additional changes to align the business and quality committees for planning oversight of at least the comprehensive health management, provider and member-centric strategies. Particular needs identified include enhancements to steering and oversight of activities related to improving clinical performance and member satisfaction.

Blue KC's Quality Improvement System conducts oversight of delegated functions. New Directions Behavioral Health (NDBH), a wholly-owned Blue KC subsidiary, is the most significant delegate, with delegation of Quality Improvement, utilization management, case management, complaints, credentialing and health coaching. Other delegates include DentaQuest, a Medicaid dental provider delegated for initial utilization review determinations, and claims handling; Health Management Corporation, for telephone nurse advice line; and Medical Evaluation Specialists, Inc. for utilization case reviews. All semi-annual reporting and oversight audits were generally acceptable and delegates were responsive to our requests for corrective action.

Staff Resources, Technology Resources and Training
During 2009, Blue KC expended considerable resources in selecting and configuring new software solutions for medical management support. Med Decision's Alineo product was chosen to replace the disappointing Care Advance system, with Phase 1 to be launched in May 2010 for the wellness-related programs. Disease management, preventive health, and case management will be rolled out in successive phases throughout 2010 and early 2011. These new modules bring process improvements which directly and indirectly support the pursuit of business excellence and provide resources for the systems and processes supporting quality improvement.

Staff Resources
Decentralization of clinical and service/operational performance improvement activities continues to bring challenges of oversight, training, standardization of reporting and communication. Limited resources in the Quality Management Department are carefully juggled and supplemented with contracted staff and restructuring of staff positions to support the top priorities of the department. An important function of the Quality Management Department is to facilitate agreement on strong interventions to improve service and clinical care that are meaningful to the population served, and measured and documented in a way that is acceptable to Blue KC leadership and external reviewers.

During 2009, the Quality Management Department continued to facilitate cross-divisional staff development through continuing education delivered through free and reduced-cost webinars and conference calls offered by NCQA, URAC, and the Blue Cross Blue Shield Association on topics related to accreditation, quality improvement projects, and best practices.

Technology, Information Systems and Access to Data
Technology advancements are critical to the success of Blue KC's strategic plan, particularly for the comprehensive health management and member-centric strategies. Reorganization of the Information Technology divisions into Technology Service Groups provides additional support of business excellence aligned by business functions such as marketing, healthcare

services, and operations. Initiatives along with important technology enhancements planned for 2010 will support comprehensive health management and have a positive impact on the strategic plan.

Most notably, Blue KC is undertaking several technology projects in support of a member-centric business model. This strategy's objective is to develop a straightforward cross-functional approach to business that includes keeping the member's perspective in mind during decision-making and development of process and tools.

Children's Mercy Family Health Partners

Overview of the Quality Improvement Program

The purpose of the Quality Improvement Program is to provide a framework for the continuous improvement of the health care provided to Children's Mercy Family Health Partners (CMFHP) members through assuring the provision of appropriate, affordable and accessible care. This is accomplished by identifying, evaluating and monitoring the quality of health care services provided to or proposed for plan members. All CMFHP providers are required to collaborate with the Quality Assurance and Performance Improvement activities. Activities include, but are not limited to:

- Assessing and enhancing member access to care and the availability of services, and assuring compliance with access standards.
- Assessing and improving the satisfaction of members, providers and CMFHP employees through the development, administration and evaluation of surveys and the processing of complaints, grievances, and appeals.
- Monitoring all delegated or subcontracted activities to ensure that they are carried out in full compliance with program standards and requirements.
- Maintaining high standards for the credentialing of physicians and other providers, and assuring these standards are met.
- Developing, implementing and evaluating clinical standards of practice, guidelines and algorithms.
- Conducting reviews and evaluations of provider performance.
- Utilizing national performance measures and benchmarks in the process of measuring, recommending, and taking action on the outcomes of patient care.
- Providing a process for evaluation of quality of care.
- Assessing the health care services provided to all members, in particular, those with special health care needs.
- Utilizing demographic data to the extent available to improve care delivery.
- Utilizing the information system for initial and reoccurring reviews of the health care delivery system.
- Ensuring input from public stakeholders to facilitate improvements in members' health status.
- Applying policies and processes to ensure CMFHP compliance with regulatory, contractual and MO HealthNet Managed care policy requirements.

Outcome Measures

For each program and performance improvement activity, outcome measures are established and, whenever possible, adopted from national standards or benchmarks. Clinical outcome measures are established for areas such as HEDIS® indicators, the Asthma Disease Management Program, the Diabetes Disease Management Program, the Depression Management Program, the Healthy Lifestyles Program (HeLP), and clinical and non-clinical performance improvement projects. Non-clinical outcome measures are established for areas where operational improvements are desired, such as member services, automation of data collection, and claims processing.

QM Philosophy

Children's Mercy Family Health Partners strives to incorporate performance improvement into the daily operations of the Plan. Operational and clinical decision-making involves thorough data collection, analysis, and evaluation. All performance improvement activities are designed to maximize clinical outcomes for members through the facilitation of access to high quality, cost-effective health care.

Overall Effectiveness of the Quality Improvement Program – Strengths

As a result of Children's Mercy Family Health Partners review of 2009-2010 quality performance and improvement efforts, the following strengths and accomplishments were realized in that timeframe:

- Developed an organization-wide assessment of readiness for NCQA and completed a majority of required processes and procedures to ensure compliance with all standards.
- Revised the quality committee structure and governance.
- Updated the case management documentation system (CARE) to ensure NCQA documentation compliance with complex case management standards.
- Implemented a major depression disease management program.
- Implemented a diabetes disease management program.
- Adopted and distributed clinical practice guidelines to support optimal care outcomes to appropriate providers – Asthma, ADHD, Bronchitis-Adult, Chlamydia screening, Depression-Adult & Pediatric, Diabetes, Lead, Low back pain, Pharyngitis-Pediatric, and Routine Prenatal care.
- Implemented adult wellness initiatives (i.e. newsletter and reminders).
- Explored other media to get education to members and providers (i.e. online community, facebook).
- Developed a formal inter-rater reliability process for clinical staff decision making.
- Implemented monitoring system for turnaround times in clinical staff decision-making that is more inclusive than the routine audit process.
- Implemented a system to begin collecting race and ethnicity information according to NCQA CLAS standards.
- Improved HEDIS® measures, including the following: Childhood immunizations Combo 2 and Combo 3, Well-child visits @ three to six years, Adolescent well-care visits, Cervical cancer screening, Chlamydia screening in women, Postpartum care, Use of appropriate medications for asthma, Comprehensive Diabetes care (CDC)-Eye care, CDC-HbA1c testing, CDC-LDL-C Screening, CDC-Nephropathy, Follow-up after mental health

hospitalization after (7) seven days and after (30) thirty days, Follow-up care for ADHD medication for Initiation phase and Continuation phase, Antidepressant medication management for Acute phase and Continuation phase, Appropriate testing for children with Pharyngitis and Annual Dental Visits.

- Implemented smoking cessation initiatives in Health Improvement.
- Continued to develop new mechanisms for detecting fraud and abuse, including claims review and an enhanced Fraud and Abuse Committee.
- Enhanced delegation agreement with New Directions Behavioral Health for NCQA compliance.

Harmony Health Plan

Overview of the Quality Improvement Program

Harmony Health Plan of Missouri, Inc. has been continuously working to improve its Quality Improvement Program and its effectiveness. During 2009-2010, Harmony has shown significant improvements in several key areas such as encounter data submission to the state, case and disease management infrastructure, implementation of the Pay for Quality program to positively affect HEDIS reporting/results, accreditation, and member and physician education.

1. Harmony Health Plan of Missouri

In January 2010 the health plan hired a Manager, Accreditation and HEDIS to meet the State of Missouri's requirment of NCQA accreditation by October 2011. This position is also responsible for quality improvement and compliance activities for the health plan. In addition a Field Social Services associate was hired to perform community outreach and education for members and providers of the health plan.

2. Accreditation

During fiscal year 2009-2010 Harmony Health Plan of Missouri began its process of acquiring NCQA accreditation prior to October 2011 to meet contractual compliance. The health plan submitted its application to NCQA in March 2010 and continues to work on compliance with standards. The NCQA look back period for the health plan began June 1, 2010 with its on-site visit scheduled for June 20 and 21, 2011.

3. Quality Improvement/Utilization Management/Case Management/Disease Management Work Plans

During fiscal year 2009-2010, Harmony Health Plan of Missouri did not have any major changes in the Quality Improvement or Utilization Management work plans. Case and Disease Management work plans underwent major changes to meet NCQA accreditation in these areas. The Missouri office meets on a monthly basis with Corporate to discuss any compliance issues and collaborates on methods for improvement.

The Lead Case Management Program was updated in April 2010 and over 40 face to face assessments have been completed through June 30, 2010. The challenge the health plan faces to meet full compliance with this activity is based on outdated member demographics. The health plan has several internal and external databases available for member demographic verification and utilizes them as needed.

4. Major Initiatives to comply with State Quality Strategy

During 2009-2010 Harmony Health Plan worked closely with other MCO's in the Eastern Region and the EQRO to continue actively participating and contributing toward the State Quality Strategy. Harmony improved Process Improvement Projects activities for Adolescent Well Child, Lead Screening, and Improving Oral Health. The following process improvement projects were discontinued:

- Medical Record Documentation by Primary Care Physicians;
- Perinatal Visits; and
- Child Consumer Assessment of Healthcare Providers and Systems

New process improvement projects Harmony Health Plan is initiating are:

- Effects of Childhood Obesity;
- Compliance with Asthma Medication; and
- Cultural and Linguistic Needs of our Members

5. Harmony Hugs

Additionally, Harmony is aggressively working on plans to improve all HEDIS measures that are part of the State's Strategy. Harmony Hug's staff substantially increased their outreach efforts and increased the percentage of members enrolled in the Program. This pre-natal outreach program is regarded as a best practice and is now contractually required.

6. Quality Improvement and Work Plan Monitoring

Harmony Health Plan monitors its quality improvement and work plan through several committees. The work plan is a working document and is updated as health plan strategies change. Harmony's Board of Directors has the ultimate responsibility for the Quality Improvement and Work Plan monitoring. However, this function is delegated to the Quality Improvement Committee (QIC), which directly reports to the Board. As described in the QI Plan, various committees report to QIC with their activities. The QIC is chaired by the Medical Director; and during 2009-2010 the committee met eight (8) times to review and monitor all QI activities and the work plan.

7. Provider Network Access and Availability

During 2009-2010, Harmony Health Plan continued monitoring and expansion of its provider network. Harmony Health Plan conducted an Access and Availability survey in November 2009. Audit results indicated that primary care physicians and pediatricians met all appointment availability and access standards and 100% of the Primary Care Providers for Adult and Pediatrics comply with the wait time standard. Audit results for OB-GYNS indicated 1st and 2nd trimester appointment availability standards were met; only 70% of the OB-GYNS met 3rd trimester and high-risk appointment availability. 88% of the PCP Providers comply with the after-hours accessibility standards.

8. Member Services

Harmony Health Plan of Missouri monitors call response times, hold times, abandonment rates, and quality for compliance with established goals. Member / Customer Service is responsible for ensuring superior services levels to its members. Customer Service handles calls from providers and members including non-English speaking members as well as calls from members who are hearing impaired. Harmony's member service department posted solid results and all results were well within established goals.

9. Cultural Competency

Harmony Health Plan policy for cultural competency establishes the following goals:

- understanding the cultural and linguistic needs of the members across all processes;
- decreasing disparities in health care delivery for various minority populations; and
- improving Harmony staff's understanding and sensitivity to cultural diversity within the organization and the members served.

Harmony continues to develop relationships with various culturally diverse and minority-based community organizations to better understand our member's needs. Harmony provides access to language translation services, bilingual associates, physicians and materials, and TTY/TDY services. During the 2009-2010 fiscal year, Harmony Health Plan will focus on a process improvement project to identify any health care disparities in various ethnic and racial groups and to develop programs to address such disparities.

10. Fraud and Abuse Monitoring

Harmony Health Plan continues to make significant improvements in this area. Harmony closely monitors fraud and abuse through the Special Investigation Unit (SIU), and locally through the compliance and regulatory affairs department. Every employee undergoes mandatory training about fraud and abuse annually. Quarterly reports are provided to QIC.

11. Population Profile

The Harmony Health Plan Medicaid population totaled 16,102 as of June 30, 2010. The majority of the enrollees, 14,514 or 82.7% of the total population are 21 years of age or younger. Females comprise 50.8% of the population while males comprise 49.2% of the population 21 years of age. Although the male and female population is almost equal in the State population, this has changed from previous years where males comprised nearly 60% of this population. The two main languages spoken by the membership were English and Spanish.

12. Improvements in Care and Clinical Services/Programs

During 2009-2010, Harmony Health Plan has demonstrated steady improvements in care and service provided to members. The Utilization Management program continued its mission of providing clinically appropriate services at appropriate settings in a cost-effective manner. During 2009-2010, the health plan enhanced its Clinical Coverage Guidelines process. Clinical Practice Guidelines are approved internally and posted for access by WellCare associates and externally by providers and members.

Case and disease management programs were enhanced by improvements to the Enterprise Medical Management Application (EMMA) software and hiring of additional staff. Workflow enhancement to Lead and OB case management has improved member identification and assessment to these programs. Program updates will continue through fiscal year 2010-2011 to meet NCQA accreditation compliance.

13. Harmony Behavioral Health

The Harmony Behavioral Health Quality Improvement Program is an evolving process in response to member, customer, corporate, regulatory, and accreditation needs and/or standards. The evaluation of 2009-2010 activities indicated opportunities for improvement; there is a

distinct need for increased availability and utilization of data as well as comprehensive data analysis to validate activities, interventions, and outcomes for continuous improvement. Harmony Behavioral Health will build on opportunities identified in the evaluation, continuing to monitor metrics and work plan standards, implementing actions for improvement in areas non compliant with established goals, and continuously evaluating structures and processes for other opportunities to ensure member, and customer, needs are met and expectations exceeded.

The health plan is scheduled to transition behavioral health services to Magellan Health Services in September 2009. Magellan Health Services is an NCQA accredited Medical Behavioral Health organization (MBHO) and will be included in the health plan's accreditation process.

14. Process Improvement Projects

Harmony Health Plan of Missouri actively participates in the following process improvement projects in cooperation with the External Quality Review Organization. In addition to the following projects, the health plan will undertake 3 additional projects during fiscal year 2010-2011.

Adolescent Well Visits

Goal is to assess the frequency and compliance of Adolescent Well Visit services obtained. The health plan's assessment of improvement strategies for the fiscal year noted:

Prior to 2010, health plan staff did not fully understand how to review, analyze, and interpret results for the process improvement project. The interventions recommended in previous years were difficult to measure with accuracy. The health plan believes its current strategies are measurable and will be monitored semi-annually for needed changes.

Previously, the plan had no clear-cut method of determining the impact, if any; the individual interventions had on the success of the project and improving the adolescent well care visit rates. The plan has determined the interventions will be reviewed semi-annually to measure the impact each intervention has in order to decide if the intervention is contributing to the success of the project and can be continued in the future to sustain needed results.

Many of the interventions have been extended from one year to the next. With regard to member education, the plan does not have a mechanism in place to determine the number of parents (guardians) who receive the member newsletter read the articles outlining the need for annual adolescent well visits, and subsequently complete care due specifically to this intervention. Similarly, due to the infrequency with which education took place in the community through Healthy Kids Club or community health fairs, the plan can not say with certainty that providing education at these events resulted in parents (guardians) completing lead testing and the these interventions were effective.

The health plan is confident the Pay for Quality program will be effective in the future in improving the rate of lead testing, however, during 2008, only 27% of the providers and/or groups who qualified received a payout for achieving the targets for adolescent well care visits. Furthermore, experiences with the providers have revealed a lack of understanding about the program. This intervention will be continued in the future.

Due to an internal problem, the company was not able to generate periodicity (reminder) letters until the 4th quarter of 2009. This intervention was not in existence long enough to affect the number of members who had an adolescent well care visit with their provider. This is a contractual item and will be continued in the future.

Currently, the only intervention that has been completed with any degree of regular frequency and effectiveness is educating the providers regarding the need for adolescent well care visits, providing monthly membership lists and quarterly non-compliant lists. Yet, we cannot say with any degree of certainty that these measures are solely responsible for the increase in the number of individuals being screened for toxic lead levels. This is an intervention that will continue in the future.

Furthermore, upon reviewing the results achieved thus far, it is apparent that the health plan has not been as effective as it desired in providing education to providers on the need for adolescent well visits to be annually. An area of opportunity is educating OB/GYN providers on completion of adolescent well visits.

Furthermore, one of the largest barriers as identified by the provider offices is completing outreach to members for services. Member demographics, specifically addresses and telephone numbers are often incorrect and/or the member has moved and disconnected their telephone service by the time the providers receive the quarterly non-compliance reports, which is the principle barrier in member outreach. The health plan needs to determine strategies to decrease the number of members with inaccurate demographic information prior to sending reports to the provider offices to be used for outreach to members.

The health plan will continue the interventions and monitor adolescent well care visits. In the future, continued attention by the health plan to the following areas will improve the effectiveness of the program's ability in the future to increase the rates and enhance our member's access to services as well as the overall health of the region:

- Determine mechanism to track metrics to determine the efficacy of individual interventions.
- Identify barriers physician offices face when completing outreach to members for adolescent well care visits.
- Continue to utilize existing reports which highlight provider's rates and non-compliant members needing adolescent well care visits.
- Determine measures that are effective in outreaching to members and the community to ensure that all adolescent receive annual well care visits.
- Periodicity letters will remind members to schedule needed services on a timely basis.

Lead Screening in Children:

The goal is to improve blood lead level outcomes in children by age one (1) and by age two (2). The health plan's assessment of improvement strategies noted:

Prior to 2010, health plan staff did not fully understand how to review, analyze, and interpret results for the process improvement project. The interventions recommended in previous years were difficult to measure with accuracy. The health plan believes its current strategies are measurable and will be monitored semi-annually for needed changes.

Education is the best tool the health plan can utilize to inform members of the impact elevated blood lead have on their children in the present and the future. Harmony Health Plan will include articles in both the provider and member newsletters annually regarding lead testing. The health plan will also continue provider visits to educate.

The health plan cannot determine the number of parents or guardians who received and read the articles; therefore, this intervention cannot be measured. This health plan has determined that this intervention will not be measured.

The health plan is confident the Pay for Quality program will be effective in the future improving the rate of lead testing. In 2008, only 60% of the providers and / or groups who qualified received a payout for achieving the targets for lead screening. It is evident from the results that a barrier still exists regarding physician knowledge and understanding of the program; and the potential monetary awards that can be attained by providers and / or groups achieving the 50^{th}, 75^{th}, or 90^{th} target percentiles.

The health plan is currently revising the Pay for Quality program and at this time the results are not available. There will be no comparison for HEDIS 2010 and HEDIS 2011 due to the pending changes to targets and distributions.

Due to internal system problems, the health plan's periodicity (reminder) letters were not generated until the 4^{th} quarter of 2009. The results of this intervention will be reported in 2010. This intervention will continue based on the health plan's contract with the State of Missouri. The health plan will be able to see the results of the periodicity letters during the CY 2010.

Previously, the only intervention that has been completed with a degree of regular frequency and effectiveness is educating providers regarding the need for lead screening, providing monthly membership lists and quarterly non-compliant lists. This intervention was based on interviews with providers which revealed a lack of understanding about the lead program. Although we cannot say that this measure is solely responsible for the increase in the number of individuals being screened for toxic lead levels. This intervention will continue in the future and has been incorporated into the health plans processes to ensure that improvement occurs on a sustained basis.

Overall, reviewing the results the health plan has achieved, it is apparent that the health plan has been ineffective in educating providers on the need for lead screenings to be completed prior to the members second birthday, but has either not done an adequate job to:

- educate providers on the need for obtaining the first lead testing prior to the members first birthday; or
- determined the barriers that are preventing parents (guardians) from obtaining lead screening prior to the members first birthday.

The health plan is developing better mechanisms of tracking the number of members receiving lead screening prior to their first birthday. Although an aggregate number is reported to the state with the HEDIS rates on annual bases, the health plan does not have a mechanism to stratify the results into individual provider and/or group rates. The health plan is planning on

working with Provider Relations and the Corporate HEDIS Specialist to determine if stratification of the data to the provider level is feasible.

Another barrier at the provider level is outreach to members to have the needed service. Member demographics, specifically addresses and phone numbers are often incorrect by the time providers receive the quarterly non-compliant membership reports. This results in the inability to outreach to the member for the service needed. The Missouri team is utilizing Paradigm, EMMA, MOHSAIC and CyberAccess (Electronic Health Record Program for MO HealthNet) to obtain current demographics for members.

In the future, continued attention by the health plan to the following areas will improve the effectiveness of the program's ability to increase the lead screening rates and enhance member's access to services as well as the overall health of the region:

- Determine mechanism to track metrics to determine the efficacy of individual interventions.
- Identify barriers physician offices face when completing outreach to members for lead screening services.
- Continue to utilize existing reports and / or create reports highlighting provider's rates and non-compliant members needing lead screening.
- Determine measures that are effective in outreaching to members and the community to ensure that all children receive a lead screening prior to their first birthday and a second lead screening prior to their second birthday.

Although the health plan cannot accurately determine which intervention impacted improvement we feel that each had an effect in its own way. In 2010, we will attempt to expand our interventions by reaching out to OB/GYNs to provide members with lead testing information during their third trimester visits, and to community agencies providing services to women and children. Additionally we will utilize Provider Relations and Medical Informatics to provide up-to-date data to providers for needed services. The health plan intends to continually assess interventions to make certain resources are being directed to areas where testing rates need improvement.

Improving Oral Hygiene

The success of the project will be evaluated by demonstrating an increase in the Annual Dental Visit total HEDIS rate for the MO HealthNet Managed Care health plans combined. The MO HealthNet Managed Care health plans generated a numerator and denominator for the measure based upon the HEDIS Technical Specifications. As required by the MO HealthNet Managed Care State contract, the calculation of the rate is audited by a certified HEDIS auditor. The MO HealthNet Managed Care health plans' report their rate by June 15th of each year. Annual Dental Visit HEDIS 2010 (2009 Measurement Year) rate serve as the baseline rate for the project. Comparisons will be made yearly to identify if there are any statistically significant increases in rates from the previous year and from the baseline.

This is a statewide collaborative process improvement project which will be converted to a health plan specific project during fiscal year 2010-2011.

Prenatal, Post Partum and Peri-natal Care
This process improvement project was not continued during fiscal year 2009-2010 as a result of incomplete or unavailable date. It is the health plan's intention to revise the process improvement project based on a new prenatal program description which establishes new measurable goals for monitoring its success.

CAHPS/Member Satisfaction Survey Data
This process improvement project was discontinued in July 2009, as the State of Missouri no longer required health plans in the state to participate in this statewide process improvement project.

Medical Record Auditing
Due to the limited sample size, trending over the past several years was a barrier to the health plan. Harmony Health Plan of Missouri continued provider interventions through July 2009 and discontinued this process improvement project at that time. The health plan performs medical record review on an annual basis as outlined in WellCare's policies and procedures. Medical Record Review results are reported to the Medical Advisory Committee and Corrective Action Plans are implemented as needed.

15. Consumer Assessment of Healthcare Providers and Systems
The Consumer Assessment of Healthcare Providers and Systems **(**CAHPS) program is a public-private initiative to develop standardized surveys of patients' experiences with ambulatory and facility-level care. Health care organizations, public and private purchasers, consumers, and researchers use CAHPS results to:

- Assess the patient-centeredness of care;
- Compare and report on performance; and
- Improve quality of care.

The overall objective of the CAHPS® study is to capture accurate and complete information about consumer-reported experiences with health care. Specifically, the objectives are to measure how well plans meet their members' expectations and goals; to determine which areas of service have the greatest effect on members' overall satisfaction; and to identify areas of opportunity for improvement, which could aid plans in increasing the quality of care provided. The health plan's goal is to achieve and exceed the 2009 Quality Compass 50th Percentile.

Although the health plan did not meet its goal, it continues its interventions by monitoring member complaints and grievances. Additionally, the health plan will propose new member interventions to improve member satisfaction and loyalty.

16. HEDIS and HEDIS-like Measures
This is the third reportable year for Harmony Health Plan in reporting HEDIS scores. Harmony is committed to improving quality of care to its members and worked diligently in achieving HEDIS goals. HEDIS 2010 (CY 2009) Medicaid HEDIS rates for Harmony Health Plan for Tier 1 measures are as follows:

- Statistically significant improvement was achieved in Cervical Cancer Screenings

- Improvement although not statistically significant were achieved for 7 Day Follow-Up for Acute Mental Illness, Adolescent Well Visits, Annual Dental Visits, Chlamydia Screening in Women, and Controlling High Blood Pressure
- Decreases although not statistically significant were noted in Postpartum Care and Well Child Visits (15 months)
- Statistically significant decrease was noted in Prenatal Care

The health plan is expecting to achieve improved HEDIS 2011 (CY 2010) rates due to better understanding of the HEDIS process and access to internal and external databases and improving pseudo claim data information entry.

Overview of the Effectiveness of Quality Program Structure

The quality structure and programs of Harmony Health Plan of Missouri has proven itself effective in 2009-2010. In January 2010, the health plan hired a Manager, Accreditation and HEDIS to oversee quality improvement processes, and initiatives as well as NCQA accreditation and HEDIS activities.

Since January 2010 the health plan has achieved the following goals:
- Updated Lead Case Management workflows to align with State requirements and obtained access to MOHSAIC a state owned database used for Lead case management
- Improved compliance with NCQA standards and guidelines
- Improve collaboration between Case and Disease by improving member engagement in needed programs

The following are challenges the health plan will need to resolve in the upcoming fiscal year:
- Accelerate improvements in HEDIS measures
- Achieve 75th or 90th percentile for most HEDIS measures required for NCQA accreditation
- Educate and motivate physicians to provide needed services in a timely manner in accordance with national guidelines
- Collect and report complete and accurate encounter data
- Improve member satisfaction with the health plan

The strategies the health plan will utilize to meet the challenges include:
- Brainstorm new innovative ways to motivate members to seek services
- Intensify physician education and feedback
- Implement proactive plans to meet compliance and reporting requirements
- Utilize community based programs to outreach to members regarding needed services

Harmony Health Plan of Missouri is diligently working on improving member health, access to services, patient safety, and education in the communities we serve. In fiscal year 2010-2011 the health plan will continue to monitor, review, improve, and update its processes and interventions for members and providers.

HealthCare USA

Overview of the Quality Improvement Program
HealthCare USA's mission is to improve MO HealthNet recipients' access to quality health care by providing a comprehensive network of providers and community organizations in order to achieve improved health outcomes. HealthCare USA achieves this mission by continuing to improve outcomes, decreasing costs and increasing membership. Quality improvement and utilization management programs support achievement of the mission in a variety of ways.

The mission of HealthCare USA's Quality Improvement Program is to increase the value of HealthCare USA services to the State of Missouri, HealthCare USA members, providers and staff by identifying opportunities and making improvement based on the measurement, validation and interpretation of data. A balanced scorecard approach is used to continuously monitor and improve key aspects of quality of care, quality of service, and safety. The Quality Improvement Program provides the framework for HCUSA to continually monitor, evaluate and improve the quality and safety of care and service provided to all members including those with limited English proficiency and diverse cultural and ethnic backgrounds. It provides an ongoing evaluation process that lends itself to improving identified opportunities. The Quality Improvement Program supports an organization-wide commitment to quality of care and service and incorporates leadership involvement in on-going improvement.

Overview of the Effectiveness of the Quality Improvement Program
HealthCare USA's 2010 annual evaluation reflects the continuous evolution of a program incorporating the best available knowledge that focuses on achieving superior outcomes by establishing positive, collaborative relationships with providers, community organizations and members across diverse settings. Through ongoing data collection and analysis, HealthCare USA's Quality Improvement Program has continued to successfully identify, prioritize and address areas of opportunity. HealthCare USA's extensive experience and record of success are demonstrated by the number and variety of programs undertaken and the results achieved in internal measures and by independent audit activities. Continuous improvements in 2009 to 2010 include, but are not limited to EPSDT ratios and HEDIS rates, outcomes of CAHPS surveys, and reducing avoidable emergency department visits. A commitment to ongoing improvement is evident in a variety of projects, such as the current preparation for pursuit of NCQA accreditation. This report shows what HealthCare USA has achieved since the last report in 2009, as well as what we are positioned to achieve in the coming year.

Missouri Care

OVERVIEW OF THE QUALITY IMPROVEMENT PROGRAM
Missouri Care Health Plan's Quality Improvement Program monitors, evaluates and improves the continuity, quality, accessibility and safety of health care services provided to members. It assesses members' care, delivery systems and satisfaction, while optimizing health outcomes and managing costs. The comprehensive program is integrated throughout Missouri Care and its provider network, and it incorporates continuous quality improvement (CQI) processes. Quality management activities are integrated with other systems, processes and programs throughout the health plan.

Quality management is a plan-wide endeavor. It is integrated by interdepartmental monitoring processes and activities, business application systems, databases that are accessible to all areas and a structure of oversight committees with representation from the plan and the provider network.

The purpose of the quality improvement program is to continuously identify areas of success and prioritize improvement opportunities with available resources to help assure delivery of care and services consistent with the Institute of Medicine six aims for care that is safe, effective, efficient, timely, equitable and patient-centered.

The Quality Improvement Program supports an organization-wide commitment to quality of care and service and incorporates leadership involvement in on-going improvement.

Specifics of the quality management program are to:

- ☐ Provide a framework for the continuous assessment and improvement of all aspects of care and services received by individual members and populations.
- ☐ Identify and improve the processes, systems and practices that will improve member outcomes.
- ☐ Promote the recognition and use of approved medical standards, practice guidelines, best practices, targeted benchmarks, data collection, analyses and clinical indicators.
- ☐ Address identified health care, service, and safety issues and bring them to satisfactory resolution according to approved medical standards, best practices, and practice guidelines.
- ☐ Collaborate with the health care community to improve members' outcomes and support community health initiatives.
- ☐ Incorporate the evaluation of technology into quality activities to improve members' health outcomes.

OVERVIEW OF THE EFFECTIVENESS OF THE QUALITY IMPROVEMENT PROGRAM

For Missouri Care, State Fiscal Year 2010 (SFY 10) was one of great innovation and success, with accompanying new challenges and opportunities. As of October 1, 2009 Missouri Care entered into a new MO HealthNet RFP/Contract. With this new contract, Missouri Care expanded benefits, state and community partnerships, and quality and service improvement programs; as well as expanding geographically to include the East and West Regions of Missouri. Missouri Care enhanced its health care home and case management models building upon the health plan's long-existing quality management and improvement infrastructure. As a result, Missouri Care received the state's highest rating for an RFP with broadened expectations for service, quality and medical cost management. Highlights of the RFP response included the unveiling of a new Cultural Competency plan and program, and the enhancement of Missouri Care's Marketing and Outreach department to include a manager and two outreach staff to service the East and West regions.

In SFY10, Missouri Care Health Plan continued to have an effective quality management and improvement program. Per the requirement of the October 1, 2009 contract with the state of Missouri, Missouri Care embarked upon preparation for Accreditation through the National Committee for Quality Assurance (NCQA). Healthcare Effectiveness Data and Information Set

(HEDIS) performance indicators continued to be closely monitored. Missouri Care expanded its HEDIS data collection to include ten additional HEDIS measures in preparation for NCQA Accreditation. This annual report describes performance in Effectiveness of Care, Access/Availability of Care, Use of Services, and Satisfaction with Experience of Care.

A major goal and accomplishment of the quality improvement program was further integration of the program across all Missouri Care departments, including Missouri Care's expanded outreach/Marketing Department.

Successful examples of this integration included the development of new cross-departmental work groups, including the Quality Improvement Work group and the Cultural Competency Committee inclusive of the Community Outreach Advisory Council on Health (COACH). There were five interdepartmental continuous quality improvement activities: Asthma Medication Compliance, Access to Dental Services, ER Utilization, Diabetes Preventive Health Care Compliance, and Follow-Up After Hospitalization for Mental Health. These initiatives represented the combined efforts of physical and behavioral health case managers, Quality staff, Provider Relations staff and Community Outreach representatives. The continued use of the Provider Preventive Care Toolkit and Site Visits was also an interdepartmental success. Quality and Provider Relations staff teamed up to inform and get feedback from providers and office personnel on methods to increase preventive health screenings and well-child care visits.

Missouri Care maintained existing partnerships and forged new partnerships with key community organizations, in its' effort to demonstrate successful care and quality service improvements for all members. Missouri Care continues to have a strong quality committee structure. During SFY 10, internal and external committee members provided helpful insight and evaluation of our quality improvement program. During this time we also improved documentation, tracking, and evaluation of quality improvement projects. The results of these activities can be seen throughout this report.

Molina Healthcare of Missouri

Molina Healthcare of Missouri (Molina) is a wholly owned subsidiary of Molina Healthcare, Inc. Molina's mission is to promote health and provide health services to low income families and individuals covered by government programs. Molina strives to provide or arrange for the provision of healthcare services to the eligible Medicaid population in the Eastern, Western and Central regions of the MO HealthNet Managed Care Program.

Molina has served patients since 1995. For all plan members, Molina emphasizes personalized care that places the healthcare provider in a pivotal role of managing healthcare. Molina is responsible for managing the provision of accessible, appropriate, cost-effective, high quality health care services for its members throughout the continuum of care, as defined by the MO HealthNet program. The health plan assists members as they move through the managed care system, reducing barriers to care, and supporting members in reaching optimal health. It is the objective of Molina to provide superior health care to its members and the community.

Overview of the Quality Improvement Program

The Quality Improvement (QI) Program is established to provide the structure and key processes that enable Molina to carry out its commitment to ongoing improvement of care and service, and improvement of the health of its members. The QI Program assists Molina to achieve these goals. It is an evolving program that is responsive to the changing needs of Molina's customers and the standards established by the medical community, regulatory and accrediting bodies.

Molina Healthcare maintains the following values, assumptions, and operating principles for the QI Program:

- The QI Program provides a structure for promoting and achieving excellence in all areas through continuous improvement.
- Improvements are based on industry "best practice" or on standards set by regulators or accrediting organizations.
- The QI Program is applicable to all disciplines comprising the health plan, at all levels of the organization.
- Teams and teamwork are essential to the improvement of care and services.
- Data collection and analysis is critical to problem-solving and process improvement.
- Every Molina employee is highly valued as a contributor to quality processes and outcomes.
- Compliance with NCQA Standards and achievement of accreditation demonstrates the commitment to quality improvement by Molina.
- Information about the QI Program is available for members and providers upon request.

Overview of the Effectiveness of the Quality Improvement Program

Through the implementation of quality-oriented goals, Molina's QI Program proves its effectiveness by encompassing the quality of acute, chronic and preventive health care as well as services provided in both the inpatient and outpatient setting to Molina's population as determined by age, disease categories, risk status and products. The scope of service includes but is not limited to, those provided in institutional settings, ambulatory care, home care, and behavioral health. Contracted provider groups, primary care and specialty practitioners and ancillary providers may render these services.

Molina has defined the following goals for the QI Program:

- Design and maintain programs that improve the care and services provided to its members. These programs must have defined outcomes within identified member populations, to allow measurement and to ensure relevancy through understanding of the health plan's demographics and epidemiological data.
- Define, demonstrate, and communicate the organization-wide commitment to and involvement in achieving improvement in the quality of care, member safety and service.
- Improve the quality, appropriateness, availability, accessibility, coordination and continuity of the health care and service provided to members. Through ongoing and systematic monitoring, interventions and evaluation improve Molina structure, process, and outcomes.
- Use a multidisciplinary committee structure to facilitate the achievement of quality improvement goals.

- Facilitate organizational efforts to achieve State and local regulatory compliance and NCQA Accreditation in 2011.